NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M5-03-1806-01

September 22, 2003

An independent review of the above-referenced case has been completed by a medical physician board certified in family practice. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by ___, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ___.

CLINICAL HISTORY
This patient injured his back at work on ___. He was treated extensively with medications, therapy, a muscle stimulator and surgeries including an IDET, lumbar fusion, hardware removal, and a selective endoscopic discectomy with anuloplasty at L3-4 and L4-5. This last note from Dr. Urrea recommends continuing the patient's Lortab, Ultracet, Ibuprofen, Soma, muscle stimulator and to continue therapy as well.

REQUESTED SERVICE(S)
Purchase of Interferential Muscle Stimulator.

DECISION
Uphold prior denial of purchase.

RATIONALE/BASIS FOR DECISION
This patient has a complicated history of back pain and extensive treatments. He continues to require a significant amount of medication over 5 months out from his latest procedure which makes his pain chronic in nature. The most recent literature and research, as well as the standard of care, do not justify the use of this device for a patient with chronic back pain with previous surgeries. It is generally accepted that this device is warranted as an adjunctive therapy in acute pain situations. Please refer to the Philadelphia Panel Study and Centers for Medicare and Medicaid Services Coverage Statement for appropriate uses for these types of devices. Therefore, the prior denial is upheld.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (20 Tex. Admin. Code 142.5©).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings/Appeals Clerk
Texas Workers' Compensation Commission
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 24th day of September 2003.